A STUDY OF PSYCHO-SOCIAL FACTORS INFLUENCING THE READMISSION OF THIRTY-FIVE MALE SCHIZOPHRENIC PATIENTS TO WAYNE COUNTY GENERAL HOSPITAL/... FROM SEPTEMBER 1948 TO DECEMBER 1949

A THESIS

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CHAPTER I

INTRODUCTION

Significance of Study

When patients from Wayne County General Hospital or any other mental hospital have improved to the point that they are permitted to return home, they, their relatives and the community are inevitably faced with certain problems and adjustments. It is commonly believed this is due partially to the lack of understanding and insight the general public has toward mental illness. No matter, however, what the aggregate of reasons, these ideas, attitudes and beliefs toward the patient and the social and related factors present while the patients are on leave, may have contributed to their readmission. This is especially true if a change to a negative or rejecting feeling or attitude towards the patient occurred due to the patient's illness and hospitalization or both. The patient would undoubtedly sense this, even if it were not openly expressed, and would subsequently begin to feel inadequate, inferior or unwanted. The so-called normal person can stand only so much stress and strain. The writer, therefore, could not help but wonder how the emotional, social and related factors in the lives of these patients may have contributed to their readmission.

The factor of "relapse" was not overlooked and it was realized that the wisest procedures and precautions in the home situation did not always prevent the necessity for re-hospitalization.

The writer was interested in the psycho-social factors which may have influenced the readmission of patients. It was believed her findings would be of value to the Wayne County General Hospital Social Service Department, to interested persons, and to herself. Consequently, she decided to study thirty-five male schizophrenic patients readmitted to Wayne County General Hospital.

Purpose of Study

This study was designed to learn the emotional, social and related factors which affected these thirty-five patients while on convalescent leave; how the patient's adjustments were affected by these factors; and finally how these same factors may have contributed to their readmissions.

Method of Study

The case study method was utilized in this study. After the cases were selected, data were collected from the patient's charts which included the following: social service progress notes, doctor's progress notes and face sheets. The data were then entered on schedules. Books, theses and articles related to this study were used as references.

Scope and Limitations of Study

This study was limited to the cases of thirty-five male schizophrenic patients readmitted to the Wayne County General Hospital, retrovertively, from December 1949 to September 1948. In order to obtain the names of the patients who were readmitted

to the hospital during the year of 1949 and the last three months of 1948, the Daily Attendance Sheets, which listed the names of all new admissions, readmissions, parolees, escapees and discharged patients, were explored. All categories other than readmissions were eliminated. The names of all readmitted patients were secured; the charts of these patients were studied in order to ascertain the diagnosis of schizophrenia. It should be noted that due to the brevity of recording utilized in this agency, it was necessary to use the cases of five patients who were readmitted during the latter part of 1948.

Of 186 male patients with a diagnosis of schizophrenia readmitted during this period, the first thirty-five (retrovertively from December, 1949) supervised by social service while on convalescent leave and also upon readmission, were selected. Male patients were chosen because of their traditional roles in the family as economic providers and because of their positions in the familial structure. Schizophrenic patients were selected because of the greater number of schizophrenic patients being readmitted to hospitals yearly.

The early childhood experiences of the patients were not considered and very little focus was placed on the lives of the patients prior to hospitalization. They were mainly studied from the convalescent leave period to the readmission.

Definition of Terms

Convalescent Leave Supervision.-- This embraces those services growing out of the primary protective and rehabilitative

function of the Hospital. Here major emphasis is upon continuing the work begun in the Pre-Convalescent Leave Study and facilitating the patient's social adjustment after the three-year convalescent leave is granted. "It calls for periodic re-evaluation of the patient's adaption to his environment with alertness to changing needs and preparedness to offer whatever help is indicated...."[2]

Pre-Convalescent Leave Study.-- When the patient has improved sufficiently so that his return to the community is being considered, a study is made of the environmental situation to which he may return. This study includes a re-evaluation of social and emotional factors seen in the light of the patient's social history, degree of illness, reactions and possible effect upon those with whom he would be associated. Effort is made during and subsequent to the study period to effect whatever modifications are indicated in order that the convalescent leave may be as constructive as possible to all concerned.

As all of the patients in this study had a diagnosis of schizophrenia, a definition of this form of illness was considered necessary.

> Schizophrenia.-- Schizophrenia is characterized by the strangeness and bizarre nature of the symptom, the absurdity and unpredictability of the affects and intellectual ideas, and the obviously inadequate connection between these two. Freud succeeded in bringing

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[1] Social Service Department Manual #3, Wayne County Consultation Center, (Detroit, Michigan, September, 1950), pp. 25-26. (Mimeographed.)

schizophrenic mechanisms into consonance with his theory of neurotic symptom formation by grouping all the phenomena around the basic concept of regression. The regression reaches back to much earlier times when the ego first came into being.

The schizophrenic has regressed to narcissism; has lost his objects; has parted with reality; the ego has broken down.[2]

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[2]Otto Fenichel, The Psychoanalytic Theory of Neurosis (New York, 1945), p. 415.

CHAPTER II

SETTING OF THE STUDY

Brief Historical Account of Attitudes toward Mental Illness

It is believed that some form of mental illness has always existed. However, in earlier times, it was probably less pronounced and less prevalent than it is today.

Attitudes toward this type of illness have also always existed. They may have been either of a positive or of a negative nature. A brief historical account of the attitudes toward mental illness gave a concise picture of the divergences of attitudes toward this form of illness through the years.

> The mental and nervous strains arising from participation in a progressively complex civilization were absent (in ancient days), life was more stratified, competition between individuals less fierce, and breakdowns attributable to social causes of this kind were probably less frequent. Dr. D. Hack Tuke, in a treatise on this subject concluded that present-day civilization, with its increasing demands on the individual, and the extreme complexity and divergences of its socio-economic relationships, inevitably carries in its wake an increase in the rate of mental disorders.
>
> In early Greece, as in Egypt, mental disorders were looked upon as divine or demoniacal visitations. There are numerous references in Greek mythology to madness sent down upon human beings by angry and displeased deities.
>
> It was Hippocrates (60-370), known as the father of medicine, who laid the basis for the rational and scientific treatment of diseases, including those comprehended under the term insanity.... He explained mental illness according to his system of humoral pathology, whereby all diseases were caused by disproportions of the four humors -- black bile, yellow bile, mucus and blood -- affecting the heat, cold, dryness

and moistness of the body.[1]

"The late seventeenth century witnessed a growing revolt, participated in by philosophers and physicians, against the superstitions of witchcraft and demoniacal possession and their cruel effects on the insane."[2]

In early colonial America, the attitudes and conditions for the mentally ill were of a cold, narrow and contemptuous nature, rather than sympathetic and understanding. The first general hospital was not established until 1732, while the first institution exclusively for the mentally ill was not opened until two decades later. During the eighteenth century, the mentally ill could be found in chains, in conditions far more miserable than those of the lowest incarcerated criminal. Up to the third decade of the nineteenth century, the general attitude regarding the curability of mental disease was dominately pessimistic. It was widely believed that mental illness was an incurable affliction.[3]

With the approach of the final decade of the nineteenth century, the reform movement in behalf of the mentally ill in some states was advancing in full swing. The three main areas were (1) removal of all mental ill persons from alms-houses; (2) discontinuance of the practice of maintaining separate

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[1]Albert Deutsch, The Mentally Ill in America (New York, 1946), p. 2.

[2]Ibid., p. 23.

[3]Ibid., p. 132.

institutions for the chronic and acute insane; (3) state control and supervision of all institutions for the mentally ill. Reform movements were also prominent at the opening of the twentieth century.

> The term mental hygiene, begun in 1843 by Dr. William Sweetzer and advanced by the great crusade of Dorothea Dix in the 1840's and 1850's, owes its modern impetus largely to Clifford Beers. In his book, A Mind That Found Itself, published in 1908, now a classic, Beers gives the personal account of his own mental illness and humiliating experiences in a state hospital. His recovery after three years determined him to devote his life to the improvements of conditions for insane patients in state hospitals.[4]

"The popular mind still held mental illness in great awe and dread. It was still regarded less as an illness than as a family disgrace and as a frightful visitation for some evil or sin committed by the victim."[5]

The entrance of the United States into World War in 1917 resulted indirectly in the recognition of the importance of mental hygiene generally. The public's attention was increasingly directed to the problem of eliminating preventable mental disorders and of improving existing methods of treating such disorders.

"The most striking development in institutions for the mentally ill during this century was the gradual ascendancy of

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[4]Thomas A. C. Rennie, "Mental Hygiene," Social Work Year Book (1949), p. 318.

[5]Albert Deutsch, op. cit., p. 303.

the curative over the custodial ideal."[6] In state after state, the use of mechanical restraint and seclusion had been reduced to a minimum. Many important tools in the realm of mental therapeutics such as psychotherapy, occupational therapy, and hydrotherapy evolved. The encouraging advances made during this period in psychiatric study did much to dispel the fatalistic attitude toward mental disease that hitherto served as a brake on progress.

> The advantages of encouraging the patient to activity, holding his interest, keeping him occupied, developing his relations with other people in healthy competition, focusing his attention outside of himself, demonstrating his special abilities by his participation in physical and mental exercise, are unquestioned. Engaging in creative activity with others makes it possible for the patient to achieve social recognition and status, with a consequent release of tension and aggression.[7]

The following was obtained from a thesis written by Miss Harriet L. Baxter:

> Concern is expressed about mental illness either in specific referral to the patient's illness and behavior, or in its general aspects.... Misconceptions about the causes or nature of mental illness are seen in questions or statements made by the relatives. /e.g./ Mrs. K. ... asked the social worker about masturbation causing mental illness.
>
> Problems center around emotional reactions to having placed the patient in the hospital.... The relatives may fear the patient will be allowed to return home. /e.g./ Mrs. N. had had a difficult time with her husband, the patient, and was worried that he would

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[6] Ibid., p. 440.

[7] Ethel B. Bellsmith, "Recent Trends in Treatment in Mental Hospitals," Journal of Psychiatric Social Work, XVIII (Summer, 1948), 8.

be released from the hospital without her consent.[8]

Miss Emily Crowell stated the following in her thesis:

> The social workers indicated that relatives' questions and anxieties are concerned with fear of abuse of their relatives and fear of blame for their responsibility in "putting away" the patient. The latter often involves confusion of hospitalization with permanent detention. Apprehension is often expressed lest the "neighbors know" of hospitalization, suggesting that stigma is still attached to mental illness or to removal of the ill person to an institution still referred to as an "insane asylum" by many lay persons. These attitudes would seem to deny existence of the illness requiring hospitalization, but on the contrary, imply that the patient is refactory even criminalistic, and in need of punishment.[9]

The Agency Setting

The writer experienced a field work placement as a social work interne at the Wayne County Consultation Center, Detroit, Michigan for a six-month period dating from September 1950 to March 1, 1951. The consultation Center is the main office and out-patient clinic of the Social Service Department of the Wayne County General Hospital and Infirmary, Eloise, Michigan. Several offices are maintained in the Administration Building at the hospital, and a supervisor, whose office is at the hospital, is on duty five days a week.

The hospital is under the supervision of the Michigan State

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[8]Harriet L. Baxter, "Problems Expressed by Relatives of Mental Hospital Patients in Social Service Interviews," (Master's Thesis, Department of Social Work, Smith College, 1944), pp. 13-14.

[9]Emily Crowell, "Some Community Attitudes about Eloise Hospital and Mental Illness," (Master's Thesis, Department of Social Work, Wayne University, 1945), p. 1.

Department of Mental Health and has two divisions, the medical division and the psychiatric division. The psychiatric division is for the care and treatment of mentally ill persons.

In all instances, it is necessary to have a legal order to restrain a patient for observation or treatment in the psychiatric division of the hospital. A petition to commit an individual in need of care may be filed by a relative, Peace Officer, or Board of County Institutions. In cases of voluntary admissions the patient signs his own petition; he also signs his own release, and must be released within five days after he signs it.

The variety of therapies utilized in this setting include: individual and group therapy, psychosurgery, electro-shock therapy, insulin therapy, sedative therapies.

Convalescent leave staff meetings are held at the hospital semi-monthly. The psychiatrists usually select patients who have improved sufficiently to leave the hospital. The life-histories, hospitalizations and the patients themselves are presented. Recommendations and suggestions from other psychiatrists are made. The clinical psychologists relate the results of the patients' performances on various tests. The psychiatric social worker active with a case gives an account of her contacts with the patient and relatives or both. She also conveys any other information deemed pertinent to the case.

The functions of the social service department include admission services, history taking, continued in-patient service,

pre-convalescent leave studies, convalescent leave supervision, and other incidental services. The primary services directed toward the treatment of the patient frequently include work with other members of the family on problems related to the patient's illness and hospitalization or both.

CHAPTER III

ATTITUDES TOWARD CONVALESCENT LEAVE

The Patients

Before the attitudes of the relatives and the patients toward convalescent leave were studied, an additional picture of schizophrenic patients was obtained.

> According to the 1937 report of the United States Census Bureau, dementia praecox (schizophrenia) accounted for 22.8 per cent of all first admissions to all state hospitals in 1937 (nearly 16,000 cases; about 1,000 more males than females).... In all age groupings through 30-34 there is a definite excess of males.
>
> Schizophrenia leads the list of cases readmitted, accounting for nearly one-third (in New York state in 1943 the figure was 39%) of all psychotic readmissions.
>
> With regard to the inevitability or the depth of the deterioration, it is reported that nearly 11,000 cases of schizophrenia were discharged from United States hospitals in 1937 (55% male). Of these, 14.2 per cent were rated as recovered, 70.7 per cent as improved, and 14.9 per cent as unimproved.[1]

A picture of the patients in this study in relation to age, sex, race, diagnosis and prognosis was obtained. All of the patients were male and all had a diagnosis of schizophrenia. The diagnosis of schizophrenia remained constant for all thirty-five patients both before and after convalescent leave. Thirteen patients were catatonic type, thirteen patients were paranoid type and seven patients were mixed type. There was no categorical diagnosis indicated for two patients.

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[1]Lawson G. Lowrey, Psychiatry for Social Workers (New York, 1948), pp. 176-177.

Twenty-seven of the patients were white, eight were Negro. There were seventeen single patients, two divorced patients; one patient was separated; one patient was widowed; thirteen were married; and one was married by common law. The age range was from twenty-one to forty-eight, with approximately one-half, sixteen of the patients, falling between the ages of twenty-one and twenty-nine.

As pertains to religion, seventeen of the patients were Protestant; sixteen were Catholic; one was Greek Orthodox; and one was Mohammedan.

Eight patients had a good prognosis upon convalescent leave; fifteen, or approximately one-half, had a fairly good prognosis upon convalescent leave; three patients had a guarded prognosis. Nine prognoses were not indicated in the records.

Family Attitudes

According to Kimball Young,

> The term attitude has both a broad and narrow meaning. In a narrow and strict sense, it means a tendency to action. In a broader sense it means the whole baggage of inner life -- the entire apperceptive mass of ideas, opinions and mental acts -- in distinction to overt action pattern or habit.[2]

In this study, the term was used in the broader sense. It was believed the attitudes of the family toward the patients' leaving the hospital would have much to do with their subsequent reactions to the patients while they were on leave.

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[2]Kimball Young, Social Psychology (New York, 1948), p. 121.

The attitudes of the relatives play a significant part for better or for worse, especially in mental illness. Whether or not the relatives look upon the patients as ill instead of wicked will determine the speed of the patients' recovery. The relatives also spare themselves much self-torture and help speed the patients in their recovery if they realize that mental illness is not a disgrace, that there should be no more stigma to mental illness than to physical disorders.[3]

In this study, only the attitudes of the dominant or key person in the home were tabulated in Table 1. To determine the dominant or key person in each family, an evaluation of the familial set-up was made whereby the person who was most prominent and influential in making decisions for the family, especially if that person was the breadwinner, was considered the key person. However, in some case records, it was cited that a particular member of the family was the dominant figure in the home.

The attitudes were classified as (1) rejecting, (2) ambivalent, and (3) accepting. The rejecting attitude was defined as the verbalized statements from key family members wherein they opposed the return of the patient to the home. This attitude may have been based on a change in personal feeling toward the patient, fear of the patient or shame of the patient. The ambivalent attitude was defined as the verbalized statements

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[3]Edith Stern, Mental Illness: A Guide for The Family (New York, 1942), p. 2.

of key family members wherein they favored or agreed to the return of the patient to the home.

A breakdown of the attitudes of the families of the thirty-five patients studied is shown in the following table:

TABLE 1

ATTITUDES OF THE KEY PERSON IN EACH PATIENT'S FAMILY TOWARD HIS CONVALESCENT LEAVE

Key Person	Total	Attitudes		
		Rejection	Ambivalence	Acceptance
Total	35	10	13	12
Wife	18	6	7	5
Parent (mother)	9	1	3	5
Parent (father)	6	2	3	1
Sister	1	1	-	-
Friend	1	-	-	1

It was significant to note that eighteen of the patients had wives who were considered key persons in their families and were fairly evenly divided as to rejection, ambivalence, and acceptance. Nine mothers, of whom over half were accepting, and six fathers were found to be key persons in fifteen of the patients' families.

Two illustrations of the rejecting attitude of a key person follow:

Case 1

John Doe was a thirty-two-year-old white, married man, who previous to hospitalization lived with his wife and daughter. He was admitted on April 1, 1948. Shortly before he was granted convalescent leave on September 15, 1948, the wife was contacted. She frankly admitted being afraid of the patient and felt he would be a bad influence on their nine-year-old daughter. She had no objection to the patient's being granted convalescent leave provided he was paroled to himself or to one of his brothers, with the promise he would never come near her house.

Case 2 describes a wife who was a key person who not only rejected the patient but feared him.

Case 2

Ben Jones was a thirty-year-old white divorced male who was married and living with his wife at the time of admittance. He was admitted on October 31, 1946. When his wife was contacted shortly before he was granted convalescent leave on October 20, 1948, she stated the patient no longer had a place in her life and she seemed to have only a passing regret for this. Her primary desire was to be free and she had filed for a divorce. The wife went on to state that she feared the patient and felt if convalescent leave was granted, he might harm her.

Ambivalent attitudes of key persons are illustrated in the following cases:

Case 3

John Brown, a forty-two-year-old white, single male, lived with his mother before admittance. He was admitted on May 25, 1948. Prior to convalescent leave, which was granted on September 30, 1948, the mother was contacted. She stated she wanted the patient home but feared he might harm someone and she would be held responsible.

The next case shows a wife who accepted the patient for convalescent leave but simultaneously objected, apparently because of financial conditions.

Case 4

Tom Jones, a forty-four-year-old white, married male, lived with his wife and two children before admittance, November 13, 1947. Shortly before he was granted convalescent leave on October 28, 1948, the wife was contacted. She stated she would accept the patient but questioned her ability to take him back unless he worked. She added she felt there was no other place for the patient to go.

Accepting attitudes evidenced by key persons are seen in Cases 5 and 6.

Case 5

Robert Hends, a twenty-seven-year-old white, married male, who lived with his wife prior to admittance, was admitted on February 6, 1948. Before convalescent leave was granted on May 15, 1948, the wife was contacted. She stated she wanted the patient home as soon as he had improved enough. She also planned to have children as soon as it appeared the patient was cured.

Case 6

Bob Rogers, a thirty-five-year-old white, single male, lived with his parents prior to admittance. He was admitted on March 19, 1945. Convalescent leave was granted on June 28, 1948. Both parents stated they wanted the patient home and would do all they could for his rehabilitation. They added the patient did not have to work except for his betterment.

It was significant to note that one-half of the patients with good prognosis had relatives with a rejecting attitude toward their convalescent leaves. Approximately one-half of the patients with fairly good prognosis had relatives who were ambivalent in their attitudes toward convalescent leave for the patients.

It might be expected from these findings that the patients would be faced with indifference and lack of understanding and

acceptance while on leave. Even with good prognosis, their adjustments might be questionable because of what might be expected from their families. While on leave the patients might be faced with conflicting attitudes and behavior from their relatives. At one time the relatives might be accepting and understanding; at another time, they might be quite hostile and reject the patients.

The prognosis of the patients at the time of convalescent leave and the attitudes of the relatives toward the patients' convalescent leaves were revealed in Table 2.

TABLE 2

PROGNOSIS OF THE PATIENTS AND ATTITUDES OF THE KEY PERSON IN EACH PATIENT'S FAMILY TOWARD HIS CONVALESCENT LEAVE

Prognosis	Total	Attitudes		
		Rejection	Ambivalence	Acceptance
Total	35	10	13	12
Good	10	5	1	4
Fairly Good	13	2	6	5
Guarded	3	-	2	1
Not Indicated	9	5	1	3

Attitudes of Patients

The attitudes of the thirty-five patients toward convalescent leave were also explored. They were classified as (1) rejecting, (2) ambivalent, and (3) accepting. None of the patients rejected having convalescent leave and returning to

their families. Seven patients were ambivalent about convalescent leave. They wanted to leave the hospital but were not certain whether their families wanted them or not. Twenty-eight patients favored leaving the hospital and resuming their positions in their familial situations. They did not express any doubts regarding whether their families wanted them or not.

Ambivalent attitudes evidenced by the patients are illustrated in the following examples:

Case 7

> Tim Cole was a forty-seven-year-old white, married man who, previous to hospitalization, resided with his wife and two children. He was admitted on January 23, 1947. When confronted with the possibility of convalescent leave, the patient stated he wanted to leave the hospital and return to his family. However, he felt rejected by his wife and relatives and did not feel either sincerely wanted him.

Case 8 describes a patient who wanted to leave the hospital and resume his family life, but felt he was not wanted.

Case 8

> John Jones was a thirty-three-year-old white, married man who, previous to hospitalization, lived with his wife and children. He was admitted on June 6, 1946. When confronted with the possibility of convalescent leave, the patient stated he wanted to go home to his family but felt he was not wanted by his wife.

The majority of the patients expressed accepting attitudes toward convalescent leave. Two illustrations follow:

Case 9

> Roger Holt, a twenty-one-year-old white, single male, lived with his parents prior to hospitalization. He was admitted to the hospital on December 11, 1947. When convalescent leave possibilities were discussed with the patient he stated he wanted to leave the

hospital and go home. He wanted to live with his family again and secure a job.

And in the second case --

Case 10

Elmer Jones was thirty years old at admission in August, 1947. He was a married, Negro male who, prior to hospitalization, lived with his wife and four children. When convalescent leave possibilities were discussed with the patient, he stated he wanted to leave the hospital, return to his family, and support them.

It was found from the preceding that the families' attitudes, which play a significant part in the patients' attitudes, were fairly evenly divided as to rejection, ambivalence, and acceptance. The patients who were confronted with ambivalent and especially rejecting families might make the poorest adjustments due to the possibility of the lack of acceptance and understanding to be expected from such families.

The family attitudes of ambivalence or rejection would be even more traumatic to the patients in that more than three-fourths of the patients were accepting of convalescent leave. They wanted to leave the hospital and resume their positions in their families.

CHAPTER IV

ADJUSTMENT WHILE ON CONVALESCENT LEAVE

It was believed many factors would influence the adjustment of the patients while they were on convalescent leave. The factors included in this study were (1) employment possibilities, (2) financial conditions, (3) social activities, and (4) emotional factors in the home and in the neighborhood.

According to Otto Fenichel,

> It is easy to see that all environmental factors that are pleasant and attractive will influence the patient in the direction of health -- those that are disappointing or lead him to temptations will be conducive to illness.[1]

As the majority of the patients returned to their immediate family homes and remained there throughout the convalescent leave period, the interpersonal relationships within the homes were considered pertinent factors in this study. It was felt the understanding and patience shown by the family members would greatly influence the adjustment of the patients while on leave.

Thirty-three of the patients returned to an urban environment; two returned to rural environments. Twenty-four of the thirty-five patients returned to their immediate family homes and remained there throughout the convalescent leave period. Two patients lived alone during the entire leave period. The remaining nine patients lived at their homes for a part of the

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[1] Otto Fenichel, op. cit., p. 446.

leave period but also resided in additional places -- either alone or with relatives outside the immediate family situation.

Social Activities of the Patients

A study was made of the social activities of the patients while on convalescent leave, and compared to their participation in social activities in pre-hospital days. It was believed their participation, in the main, during both periods would be limited, but no matter how limited, it was felt the patients would gain by some degree of participation. The activities would keep the patients occupied and help them to extend themselves and come in contact with others.

> It is fairly common, but hardly universal, to find that these patients /schizophrenic patients/ have a long history of being "odd" in various ways. Special stress has been laid on the "shut-in" type of personality -- the unsocial, withdrawn person who has no intimate friends and tends to live within himself in a world of fantasy.... If one or more members of the family are genuinely interested and sympathetic yet firm in attempting to socialize the /paroled/ patient, then a reasonably adequate social adjustment may be maintained for some time. This may, however, be limited to the home or to some simple routine of occupation....[2]

"Engaging in creative activity with others makes it possible for the patient to achieve social recognition and status, with a consequent release of tension and aggression."[3]

In this study, there was a decrease in the participation in social activities of fifteen of the thirty-five patients

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[2]Lawson Lowery, op. cit., pp. 180, 193.

[3]Ethel B. Bellsmith, op. cit., p. 8.

as compared to pre-hospital days. The patients in the main, remained in the homes, read or listened to the radio for enjoyment, and seldom left the home. Four of the patients returned to homes where there was decided financial stress and strain, which seemed to be a contributing factor to the decrease in their participation in social activities. Seven of the patients were confronted with homes where there were damaged interpersonal relationships and marital conflicts. These patients and their wives had nothing in common and never went out together, or the wives were seeking divorces, or, as in one case, the wife would not accept the patient. He lived alone while on leave, brooded, and worried over his family situation and was practically void of social activities. There was a decrease in the participation in social activities of three additional patients because of their own choice. One other patient evidenced a decrease in participation in social activities because of the attitudes of the neighbors. They laughed at and ridiculed the patient, causing him to remain in the home more than usual.

Nineteen patients participated in social activities in primarily the same degree as in the pre-hospitalization period. It was noted this participation was to a very limited degree and usually consisted of an occasional movie. Two of the nineteen patients' participation in social activities remained the same but was of a more active nature.

From the above, it was found that more than one-third of the patients evidenced a decrease in participation in social

activities as compared to pre-hospital days. Nineteen patients participated in social activities in primarily the same degree as in the pre-hospitalization period. This participation, however, was to a very limited degree. Only one patient showed an increase in participation in social activities.

The limited degree of participation in activities by the nineteen patients was not unexpected as it is usually limited for patients with this diagnosis. The decrease in participation, however, might have meant the patients were even more confined to their homes and had the opportunity to focus undue attention on themselves and their illness. The lack of and the extremely limited degree of participation in social activities by all except one of the patients prevented use of a constructive means for the patients to extend themselves and to gain social recognition and status. This further prevented use of a means of release of tension and aggression.

Employment History of the Patients

The value of the patients' obtaining employment while on leave cannot be overestimated. This is especially true of the patients who were the breadwinners (and breadwinners are usually males) in their families prior to hospitalization.

> The family may be looked upon as a small social unit which provides for the physical, mental, and moral and spiritual welfare of its members. Under normal circumstances the earnings of the father procure adequate food, clothing and shelter for all the members of the family.[4]

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[4]Dom Thomas Verner Moore, Nature and Treatment of Mental Disorders (New York, 1944), p. 188.

The possible deflation to their egos upon returning home to have a wife or mother support them cannot be overlooked. However, there are additional difficulties to be faced with the paroled patients in obtaining work. The attitudes of the former and new employer and employees and the over-taxing and highly competitive jobs would be expected to have a decisive influence on the convalescing schizophrenic patients.

> The difficulty of providing a suitable occupation is one of the stumbling blocks to successful social adjustment. In the hospital the patient may do well in occupational therapy or in any one of a large number of maintenance jobs. There is little pressure in such jobs and competition is at a minimum. The schizophrenic often has impossibly high standards for himself and quickly abandons effort and withdraws if pressure is great or competition is strenuous.[5]

In this study, it was found that twenty-eight of the thirty-five patients obtained employment while on leave. Of these twenty-eight patients, twelve were employed as factory workers; two as inspectors; the remaining fourteen were employed as common laborers. Eight of the twenty-eight patients returned to former jobs. Two of these eight patients were faced with considerable difficulty and delay because they had been patients in a mental hospital. Their former employers hesitated to rehire them as they were not certain of the state of the patient's mental health. Both of these patients were in need of jobs as the financial situations in their homes were poor. The remaining six of the eight patients who returned to former jobs were

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[5]Lawson Lowery, op. cit., p. 193.

not faced with any known difficulties.

The additional twenty patients who obtained employment while on leave were not faced with any known amount of difficulty in securing jobs. However, nine of the patients offered several complaints of their jobs. These complaints included the following: The jobs were too noisy; some were too taxing and confining; the jobs did not pay well and the patients were assigned to different duties on a job. As a result, these patients were dissatisfied with their jobs; many felt inadequate in that they were not able to secure a better paying job; and many worried and brooded over the conditions.

Seven of the thirty-five patients were unemployed during convalescent leave. Of these, two attempted to secure work. One patient was returned to the hospital because of a recurrence of his illness; the other patient was denied work because he did not have legal status. It was noted in his record that this patient's unemployment aggravated the tension and frustration in the patient and he resented being dependent upon his family for spending money.

Seven patients received different forms of public assistance while on leave. Neither of these patients were faced with difficulty in obtaining such assistance nor did they have to wait long periods of time in order to get the assistance. All were confronted with financial stresses and five had attempted to secure jobs but were unsuccessful. Two were working but their wages were inadequate to meet their financial needs. All

seven patients stated they felt the assistance necessary to care for themselves and their families but seemed to conceive of it as a last resort.

Five families of other patients received some form of welfare assistance before and during the patient's convalescent leave.

Evaluation of Adjustments

The adjustments of the patients while on convalescent leave were evaluated from social, economic and emotional standpoints. The understanding, patience and consideration shown the patients by their families while on leave and the emotional stability and security within the homes were deemed prominent factors. In this connection, the attitudes, understanding and consideration shown by neighbors were also considered important.

The patients' abilities to live in everyday surroundings while on convalescent leave determine whether they shall be released or readmitted to the hospital. The patients on leave should not be pampered. They will readjust themselves at home and socially if they are not over-protected by their families and will learn just as the convalescent child learns -- with guidance, to live happily without constant attention. The convalescent leave patients should be treated as far as possible like the other family members.[6]

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[6]Edith Stern, op. cit., pp. 101-103.

No matter how wisely or bravely the relatives are, sooner or later, someone will probably pass a remark like "he's crazy," or will tap his forehead significantly. If the convalescent patients learn of any slurs cast upon them by neighbors, the relatives should not deny they were made.[7]

The types of adjustments made by the patients were categorized as (1) good, (2) marginal, and (3) poor. A good adjustment was defined as one wherein the patient was financially secure, either by obtaining work which was not overly taxing or confining, or by receiving adequate public assistance; the patient participated in some form of social activity; the family showed understanding and acceptance of the patient and he did not feel insecure or rejected by the family. A marginal adjustment was defined as one wherein the patient had full or part time employment or received public assistance. The jobs were overly taxing or confining or the public assistance could barely meet the patient's needs; the patient participated in a limited number of social activities; he lived in a home where there was little understanding and patience shown him, but at some time during the leave period the understanding and patience of the family improved. A poor adjustment was defined as one wherein the patient was financially dependent on the family or some form of public assistance; there was a decrease in the patient's participation in social activities; he lived in a

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[7]Ibid., p. 112.

tense, unsympathetic atmosphere where the family lacked understanding and patience throughout the convalescent leave period.

It was found that no patients made good adjustments while on leave; eleven made marginal adjustments; twenty-four made poor adjustments.

Two illustrations of marginal adjustments made by patients follow:

Case 11

> This is the case of U. V., a twenty-three-year-old Negro male who lived with his wife and mother-in-law during convalescent leave. Later he and his wife lived alone. U. V., returning to his former occupation, received no objection by his employer as long as the hospital filed certain papers. A two-month period elapsed between the time the patient left the hospital and began work. There was no decrease in the patient's participation in social activities but they remained very limited. This was due primarily to his job which was very confining and required long hours. In the home the patient and the mother-in-law bickered constantly. She wanted to control the patient and his family, which he resented. There was a long period of persuasion on the patient's part to get the wife to move away from the mother-in-law.

Case 12 illustrated how a patient made a marginal adjustment in the home of his parents while on leave.

Case 12

> W. S., a thirty-five-year-old white, single male, lived with his parents while on leave. The patient worked only four days and was otherwise dependent on the family. There was a decrease in the patient's participation in social activities. In the home, the mother, who was always over-protective of the patient, babied and pampered him. The understanding and patience of the father for the patient was very limited. He and the patient argued frequently.

Poor adjustments made by the patients while on leave are seen in the following cases:

Case 13

Y. Z., a thirty-three-year-old white, married patient, lived with his wife and three children during convalescent leave. He did not return to his former job but to a similar one. One month elapsed before he began work, which he did for four months. There was no decrease in the patient's participation in social activities but they remained extremely limited. In the home, the wife talked to the patient in a disrespectful way, scolded and belittled him. She would not allow him to do anything to help her; then would complain that he would not. During the leave, the wife tried various means to get the patient returned to the hospital, but his lack of violence contra-indicated his return. The wife finally used arrests as a means of getting the patient back in the hospital.

The following case illustrated how a patient was financially dependent on his family and was confronted with unsympathetic and antagonistic persons while on leave.

Case 14

This is the case of A. W., a thirty-year-old single, white, male who lived with his parents and two brothers while on leave. The patient did not work while on leave nor did he receive any form of public assistance. He was financially dependent on his family. The patient's participation in social activities remained primarily the same as in pre-hospital days, which was extremely limited. In the home, the mother dominated the patient; pried into his every thought and action, and would not let him do anything he liked to do. The father was alcoholic and antagonistic towards the patient. When inebriated the father beat the patient and the rest of the family. There was constant bickering between the parents. The patient admitted being ashamed of his father's drinking and was also confused and unhappy because of his parents' relationship with each other. He went on to say there was no love in the home and there was no one to whom he could talk.

The adjustments of the patients, in the main, were poor. More than two-thirds of the patients made poor adjustments; approximately one-third made marginal adjustments. This was

found to be due primarily to the rejection, lack of acceptance and understanding shown by the families. The patients were not treated as other members of the families and it was obvious they were "different." Financial stresses and strain and difficulties on jobs also affected the patients' adjustments. A great majority of the patients were void of social activities or their activities were extremely limited.

All of these factors contributed toward making for poor adjustments for more than two-thirds of the patients while on leave.

The prognosis of the patients' at the time of convalescent leave and the types of adjustments made by the patients while on leave were revealed in the following table:

TABLE 3

PROGNOSIS OF THE PATIENTS AT CONVALESCENT LEAVE AND TYPES OF ADJUSTMENTS MADE ON CONVALESCENT LEAVE

Prognosis	Total	Adjustments		
		Good	Marginal	Poor
Total	35	-	11	24
Good	10	-	5	5
Fairly Good	13	-	3	10
Guarded	3	-	1	2
Not Indicated	9	-	2	7

It was significant to note that one-half of the patients with good prognosis made poor adjustments while on leave. More

than three-fourths of the patients with fairly good prognosis made poor adjustments while on leave. Of the total number of patients on leave, sixty-eight per cent made poor adjustments.

It might be concluded that the patients with good and fairly good prognosis who made poor adjustments while on leave were faced with difficulties in their environments, especially in the homes. The lack of understanding and acceptance by family members, causing the patients to feel like outsiders, resulted in the patients' remaining to themselves and focusing attention on themselves, thus hastening their recourse to fantasy. The limited degree of participation in social activities by the majority of the patients and the problems with which many were confronted in their job situations were seen as additional difficulties in the patients' environments while on leave.

CHAPTER V

PSYCHOLOGICAL FACTORS PRESENT AT TIME OF READMISSION

Family Attitudes

Just as the attitudes and feelings of the family towards convalescent leave for the patients were considered pertinent, so were the families' attitudes and feelings toward the readmission of the patients considered significant. The latter would portray (1) something of the interest shown the patient while he was readjusting himself to the home, (2) the understanding and insight that the family members had of the patients' illness, and (3) an indication of the interest and cooperation to be expected from the family after the patients were readmitted.

The attitudes of key family members toward convalescent leave were described (see Chapter III). These attitudes toward readmission were classified as (1) rejecting, (2) ambivalent, (3) accepting, (4) relief, and (5) not indicated. The rejecting attitude was defined as the verbalized statements from key members of the family wherein they opposed the return of the patient to the hospital. The ambivalent attitude was defined as the verbalized statements from key family members wherein they accepted and opposed simultaneously the return of the patient to the hospital. The accepting attitude was defined as the verbalized statements of key family members wherein they favored or agreed to the return of the patient to the hospital, with the feeling that this was necessary and for the betterment

of the patient. The attitude of relief was defined as the verbalized statements of key family members wherein they wanted the patient returned to the hospital. The basis for this attitude was that re-hospitalization would mean freedom from the stress and strain of the responsibility for the patient; it would alleviate the interference the patients presented in their personal lives. The attitude classified as "not known," was so stated because the key family members were not contacted.

A breakdown of the attitudes of the families of the thirty-five patients studied is shown in the following table:

TABLE IV

ATTITUDES OF THE KEY PERSON IN EACH PATIENTS FAMILY TOWARD HIS READMISSION

		Attitudes				
Key Person	Total	Relief	Rejection	Ambivalence	Acceptance	Not Known
Total	35	16	1	2	12	4
Wife	18	9	-	1	4	4
Parent (Mother)	9	3	-	-	6	-
Parent (Father)	6	3	1	1	1	-
Sister	1	1	-	-	-	-
Friend	1	-	-	-	1	-

It was significant to note that approximately one-half of the family members maintained an attitude of relief at the time of the patients' readmission, nine of whom were wives. According

to the records, the four attitudes categorized as "not known" were also those of wives. In one case the wife had divorced the patient; in the remaining three, the wives were obtaining divorces.

Two illustrations of accepting attitudes of key persons follow:

Case 15

A. B. was a thirty-five-year-old white, single male who lived with his parents while on convalescent leave. The mother was the key person in the home. Upon his readmission, the mother stated she felt the patient should be returned for his best interest. She added she would visit the patient and bring him clothing and spending money.

In case 16, a father who was the key person, expressed an accepting attitude towards the patient's readmission.

Case 16

C. D. was a twenty-one-year-old Negro male who resided with his father while on convalescent leave. The father was his only relative. Upon the patient's readmission, the father stated that he felt the patient should return and receive help. The father added if convalescent leave was granted again, the patient could return to him.

Attitudes of relief expressed by key persons are indicated in Cases 17 and 18.

Case 17

E. F., a thirty-two-year-old white married male, lived with his wife while on convalescent leave. When the patient was readmitted, the wife stated frankly that she was glad the patient was back in the hospital. She had been dissappointed because the patient had not worked regularly while on leave. The wife went on to say that she did not want the patient back in the home again; she only wanted a divorce. She felt she had no friends because of the patient.

Case 18

This is the case of G. H., a twenty-eight-year-old Negro male who resided,while on convalescent leave,with his wife. Upon the patient's readmission, the wife stated she wanted the patient out of the home and was satisfied now that he was back in the hospital. She admitted being afraid of the patient and was getting a divorce.

It might be concluded that the majority of the families thought of the patients as "burdens" -- persons who interfered with their social lives; who demanded undue attention and required too much responsibility. As a result, the families felt relieved when the patients were readmitted.

Attitudes of Patients

The attitudes of the thirty-five patients upon readmission were also explored. Their attitudes were classified as (1) accepting, (2) hostile, and (3) dejected. The accepting attitude was defined as the verbalized statements from the patients wherein they favored or agreed to return to the hospital for their own betterment. The patient was cognizant of familial and financial conflicts in his life and saw them as disturbing factors. He felt a return to the hospital would be for his betterment. The hostile attitude was defined as the verbalized statements from the patients wherein they felt re-hospitalization unnecessary; were uncooperative and hostile upon readmission, and felt their families were using readmission as a means of "getting rid" of them. The attitude of dejection was defined as the verbalized statements from the patients wherein they stated they felt their families wanted to "get rid" of them again; these patients were depressed and hurt upon readmission, having worried

over financial or familial conflicts, or both.

It was significant to find that approximately one-half, sixteen patients, expressed an attitude of dejection upon readmission. Eleven patients maintained an attitude of acceptance upon readmission. Eight patients expressed a hostile attitude upon their readmission.

Two illustrations of accepting attitudes of the patients follow:

Case 19

> I. J., a thirty-five-year-old-white, single, male, lived with his parents and two brothers while on convalescent leave. Upon readmission, the patient stated he had come back voluntarily to "escape" family pressure and wanted to go some place he would be accepted. He felt the home environment exercised an oppressive influence upon him in that it tended to obstruct any action on his part. He felt by putting himself out of the home and family influence, he would be able to make further strides toward recovery.

Case 20 illustrated how a patient felt he needed to be readmitted and accepted re-hospitalization for his own betterment.

Case 20

> K. L., a forty-seven-year-old white, married, male lived alone while on convalescent leave. His wife was obtaining a divorce. Upon readmission, the patient said he needed to return. His marital problems, especially his wife's obtaining a divorce, had been worrying him considerably. This was accentuated because he was of Catholic religion. The patient recognized his increased nervousness and headaches and returned on his own volition.

Hostile attitudes expressed by the patients upon readmission are evidenced in the following illustration:

Case 21

M. N., a thirty-three-year-old white, married, male, lived with his wife and three children while on convalescent leave. Upon readmission, the patient was very hostile and uncooperative. He stated he had resented his wife's action in getting him back into the hospital. He felt the rejection from his wife keenly and resented his return to the hospital.

Case 22 denoted how the attitudes and interference of neighbors created a hostile attitude in a patient upon his readmission.

Case 22

O. P., a twenty-two-year-old single, white, male, lived with his parents while on convalescent leave. Upon readmission, the patient was extremely hostile to his neighbors, who had him readmitted. He felt they had interfered with his life on the outside and would not give him a chance to adjust.

Two illustrations of attitudes of dejection follow:

Case 23

Q. R., a forty-one-year-old married male, lived with his wife while on convalescent leave. Upon his readmission, the patient stated he was hurt because of his marital difficulties, especially his wife's having a "friend". He felt his wife had rejected him and no longer wanted him. His employment difficulties while on leave also worried him.

The following case shows how unhappy, frightened and rejected this patient felt upon readmission:

Case 24

S. T., a twenty-two-year-old white, single, male, lived with his father and sister while on convalescent leave. Upon readmission, the patient stated he was frightened, unhappy, and felt rejected by his family. He felt the family was taking out their anger on him by sending him back to the hospital. The patient continued to worry about his unemployment while on leave.

Attitudes of Neighbors

It was only in one case that the attitude of the neighbors proved significant in a patient's adjustment. They were fearful of the patient and felt he was harmful to the community. Upon his readmission, the patient was very hostile and resentful toward his neighbors. He had resented being referred to as the "crazy man." He did not molest any one, not even when the neighbors laughed at him. The patient felt the neighbors had interfered with his outside life.

It might be concluded from the preceding that most of the patients during leave resided in unhealthy, rejecting atmospheres where the family members lacked understanding or acceptance of them. It was significant to note that approximately one-half of the families expressed attitudes of relief upon the patients re-admissions and approximately one-half of the patients evidenced attitudes of dejection upon their readmission.

CHAPTER VI

SUMMARY AND CONCLUSIONS

Through the years, the attitudes, care and treatment of the mentally ill have been, in the main, of a pessimistic, unsympathetic nature. Many held the mentally ill patient in awe and dread and believed his condition was a result of demoniacal possession. Consequently, the harsh treatment he received in hospitals and in homes was not unexpected. It was not until the present century that a positive change in these areas toward the mentally ill was made. Even today, however, some of the pessimistic attitudes and the unsympathetic care and treatment for the mentally ill continue unchanged.

This was a study designed to learn the social, emotional and related factors which affected thirty-five mentally ill patients while on convalescent leave from Wayne County General Hospital. It was further designed to learn how the patients' adjustments were effected by these factors and finally how these factors may have contributed to their readmission.

In exploring the attitudes of the families towards the patients' leaving the hospital, the attitude of the dominant or key person in the home was obtained. The dominant or key person in each family was determined by an evaluation of the familial set-up. The prominent and influential person in making decisions for the family, especially if that person was the breadwinner, was considered the key person.

The attitudes were classified as (1) rejecting, (2) ambivalent, (3) accepting. It was significant to note that eighteen of the patients had wives who were considered key persons in their families and their attitudes were fairly evenly divided as to rejection, ambivalence and acceptance. Nine mothers, of whom over half were accepting, and six fathers were found to be the key persons in fifteen of the patients' families. The attitudes of the patients toward convalescent leave were also explored. Seven patients were ambivalent about convalescent leave.

It was found there was a decrease in the participation in social activities of fifteen of the thirty-five patients as compared to pre-hospital days. Nineteen patients participated in social activities to primarily the same degree as in the pre-hospitalization period. Only one patient evidenced an increase in participation in social activities.

Twenty-eight patients obtained employment while on leave. Almost one-half of these patients were faced with difficulties on their jobs. Such complaints as a job being too taxing or confining or paying inadequately were common. The remaining seven of the thirty-five patients were unemployed while on leave.

Seven patients received different forms of public assistance while on leave. These patients were faced with financial stresses and five patients had the ego strength to look for jobs but were unsuccessful. As a last resort, they secured public assistance.

The adjustments of the patients while on leave were evaluate

from social, economic and emotional standpoints. It was found that eleven patients made marginal adjustments; twenty-four made poor adjustments. No patients made good adjustments. The poor adjustments appeared to be due, in the majority of cases, to the fact that the patients lived in tense, unsympathetic atmospheres where the families lacked understanding and patience; a decrease in participation in social activities was noted. The patients in these homes were usually left out of the family plans; there was little or no companionship and happiness in the homes. On the other hand, in some homes the patients were over-protected by the relatives. To summarize, in the homes where the patients made poor adjustments the rejection and resentment felt towards the patients was openly expressed. This made the patients feel inferior, unwanted and inadequate. They began to remain to themselves more and more and as the patients in this group participated in social activities to an extremely limited degree or not at all, there were no constructive avenues for the release of the hostility, aggression and resentment they felt. Possibly, their only recourse was to focus their attention on themselves and their illness. This may have caused them to worry about having been mentally ill, and the continued brooding, worrying and remaining alone may have hastened the recurrence of their fantasy life.

The lack of social activity, especially group activity, the difficulties and dissatisfaction faced in job situations, and possibly most important of all, the lack of understanding

and acceptance shown in the families, made these patients feel inferior and unwanted. By remaining to themselves, they possibly found satisfaction in their hallucinations and fantasies.

The attitudes of the families towards the patients' readmissions were explored. It was found that approximately one-half of the families maintained an attitude of relief at the time of the patients' readmissions. Approximately one-half of the patients expressed an attitude of dejection upon readmission. Eight patients expressed a hostile attitude upon readmission, feeling that their families had not wanted them and were "getting rid" of them.

APPENDIX

SCHEDULE

Number: Age at Admission: Marital Status:
Race: Nationality: Religion:
Diagnosis:
Prognosis at time of Convalescent Leave:
Date of Admission:
Date of Convalescent Leave:
Date of Return to Hospital:

Location of Home: Urban: Rural:
Person most interested in Patient:
Spouse: Relative:
Parent: Other:
Children:

Attitude of Family Toward Convalescent Leave

Attitude of Patient Regarding Convalescent Leave:

Patient's Adjustment:

With whom did he live while on leave?
Did he work while on leave? If so, did he work at former occupation?

Attitude of employer and employees toward patient. (If noted in record)

What was lapse of time between leaving the hospital and beginning work?

Reasons for lapse of time.

The period of time patient worked.
What was his means of supporting himself while on leave?

Did the patient need Public Assistance? If so, was it received? How long after he left the hospital was it received? Patient's attitude toward any form of public assistance.

Any indications of increase or decrease in social activities of the family or the patient after the patient's return home?

Psychological Factors at the time of Patient's Return to Hospital.

Attitude of the family at the time of patient's return to the hospital.

Evaluation of the adjustment of the patient at the time of returning to the hospital.

The patient's attitude at that time.

Effect this had on the patient.

The attitude of the neighbors (if in record) at the time of the patient's return to the hospital.

Effect this had on the patient.

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